

Care Plan (Sample Format)

Recipient Medicaid
 Name _____ ID number _____ Agency Name _____


[illegible]

Appendix 13 (Continued)

Recipient's name: _____ Medicaid ID number: _____ Agency name: _____

Care Coordinator Checklist (page 1)

CONTENT OF CARE COORDINATOR VISITS (Please check the activities or items related to that visit.)											
DATE:											
Location of contact: Office Visit											
Home visit											
Telephone visit											
Gestational age											
Discuss recipient's concerns											
Follow up on previous referrals											
Continue screening for abuse, stress, need for mental health and social services											
HEALTH PROMOTION/EDUCATION											
Continue nutrition counseling, referral											
Risks to avoid: medications, chemicals, etc.											
Monitor smoking, alcohol, drug use											
Managing common discomforts											
Warning signs in pregnancy											
Promote breastfeeding											
Maternal seatbelt use, infant car seat safety											
Preterm labor symptom recognition											
Preparation for labor/birth											
Promote prenatal/parenting classes											
Signs of labor -- where/when to go											



Signature

**Appendix 13
(Continued)**

Care Coordinator Checklist (page 2)

CONTENT OF CARE COORDINATOR VISITS (Please check the activities or items related to that visit.)											
DATE:											
TRANSPORTATION ASSISTANCE											
Contacted county transportation											
Contacted HMO transportation											
Other, specify:											
CHILD CARE ASSISTANCE											
Contacted county child care assistance											
Other, specify:											
SPECIAL COMMUNICATIONS											
Contacted primary care provider											
Received information from primary care provider											
Client needed extra appointment reminders and follow up											
Communications with referral providers											
OTHER:											

Signature